PLACER COUNTY VETERANS SERVICE OFFICE
1000 Sunset Blvd. Suite 115, Rocklin, CA 95675 (916)780-3290 FAX: (916)780-3299

Pension w/Aid & Attendance Verification Sheet

Surviving Spouse

Veteran Name: _____ File/SS#: _____

☐ Intent to File (21-0996) ☐ Appointment of VSO as Claimant's Rep (21-22)
☐ Third Party Form (21-0845) ☐ Alternate Signer Form (21-0972)
☐ DD-214 or other Honorable Discharge Paperwork

☐ Application for DIC, Survivors Pension and/or Accrued Benefits (21P-534EZ)

☐ Income & Asset Statement (21P-0969)
☐ Medical Expenses – Ongoing monthly expenses

☐ A&A Worksheet (3 pages) ☐ Marriage Certificate ☐ Death Certificate

☐ Examination for Housebound Status or Permanent Need for Regular Aid and Attendance (21-2680) (Completed and signed by a Physician)
☐ Worksheet for Assisted Living, Adult Day Care of Similar Facility (21P-534EZ)
☐ Worksheet for In-Home Attendant Expenses (21P-534EZ)
☐ Care and Expense Statement for Caregiver/Facility (2 pgs.) & Proof of Monthly Payment

☐ **Verification of Gross Income from all Sources**
- ☐ Social Security Award Letter
- ☐ Pension(s)
- ☐ IRA, Stocks, Bonds, CD's & Annuities
- ☐ Dividends/Interest (previous tax year)
- ☐ Rental Property ☐ Report of Income from Property or Business (21P-4185)

☐ **Verification of Assets**
- ☐ Current Bank Statements, showing all pages
- ☐ Banking Info: Name of Financial Institution, Account & Routing Number
- ☐ Personal Property Documents (Rental)
- ☐ Trust Document, all pages

☐ **Verification of Past Marriages for both Veteran & Surviving Spouse**
(If married more than once)

SERVING THOSE WHO SERVED

COUNTY OF Placer
HEALTH & HUMAN SERVICES
VETERANS SERVICES

Pension with Aid & Attendance packet instructions in completing all the required documents for you to complete and return to Placer County Veterans Service Office.

Intent to File – VA form 21-0966: Will need to be signed & dated by the Surviving Spouse and returned to our VSO. (Unless one has already been filed).

Appointment of VSO as Claimant's Representative – VA form 21-22: Will need to be signed & dated by the Surviving Spouse and returned to our VSO. (Verification timeframe - 30 days)

Third Party Form – VA form 21-0845: Will need to be completed, signed & dated by the Surviving Spouse and returned to our VSO. (Only if needed; Instructions are included).

* If surviving spouse cannot sign, alternate signer can sign with proof of durable power of attorney.

Alternate Signer Form – VA form 21-0972: Will need to be completed, signed & dated by the alternate signer and returned to our VSO. (Only if needed; Instructions are included).

The first set of pages (1-3)

Aid & Attendance Worksheet - Must be filled in its entirety.

Page 1: Complete all sections (I – V).

Page 2: Complete all sections (VI – VIII). Enter all sources of income, medical expenses, assets and provide current verification. If the Surviving Spouse does not have the income, medical expense, or asset, you must enter None or N/A in the spot provided for the Surviving Spouse.

- Provide current statements, showing all pages for all income & assets for the Surviving Spouse. **Ex:** Social Security Award letter, Pension, Interest/Dividends for all accounts including Savings or Checking accounts that accrue interest and rental property.

Page 3: Is requesting prior marriages for the Veteran & Surviving Spouse. If you were married more than once, you must complete this page providing the date & location of the prior marriage(s) in addition to the date & location it ended.

- If you had no prior marriages, please write N/A.

Application for DIC, Survivors Pension, and/or Accrued Benefits -VA Form 21P-534EZ

- Complete the application to the best of your ability and return to our Veteran Service Office for review.

COUNTY OF Placer
HEALTH & HUMAN SERVICES
VETERANS SERVICES

Quick Instructions for Sections IX – XI:

Information About Medical Expenses or Other Expenses

Medical Expenses (Section IX): Enter the monthly amount of the Surviving Spouse's ongoing medical expenses paid each month.

- This includes IHSS payment, medications, facility/nursing home charge, continence products, Social Security monthly premium & other medical premiums.
- Please refer to the Quick Reference Guide, page 2 and 3, attached.
- **Verification for each medical expense will be required.**

Section X & XI - Page 11

Direct Deposit Information (Section X): Select the type of Account (checking/savings). Provide the name of Financial Institution, Account & Routing Number.

Claim Certification and Signature (Section XI): Only Signature of Surviving Spouse is required in box 50A **(do not date).**

Worksheets (Facility or In-Home Care)

(Use the Worksheet that is applicable to the Surviving Spouse's situation)

21P-534EZ (Page 12) - Worksheet for an Assisted Living, Adult Day Care or Similar Facility

Must be answered & completed by the person certifying for the Facility

- If Step 1 is answered "NO," then proceed answering the remaining Steps of the worksheet.
- If Step 1 is answered "YES," then skip to bottom of the worksheet and answer Steps 7 & 8.

Step 8:

- **First Line:** Name of Surviving Spouse.
- **Second Line:** Name of the Facility.
- **Third Line:** Address of Facility.
- **Fourth Line:** Signature of the person certifying for the Facility (Manager, Supervisor, Administrator, etc.) and provide their printed their name.
- **Fifth Line:** Title of the person certifying for the facility & date.

COUNTY OF Placer
HEALTH & HUMAN SERVICES
VETERANS SERVICES

Worksheets (Facility or In-Home Care)

[Use the Worksheet that is applicable to the Veteran's situation]

21P-534EZ (Page 13) - Worksheet for In-Home Attendant Expenses

All 7 Steps must be answered by the care provider/attendant.

Step 7:

- **First Line:** Name of Surviving Spouse.
- **Second Line:** Name of the care provider/attendant.
- **Third Line:** Signature of care provider/attendant and their printed name.
- **Fourth Line:** Enter **Care Giver**.

Care & Expense Statement (2 pages)

Complete & enter the information on behalf of the Surviving Spouse.

Section 1: Entire section must be completed.

- **Letters J & M** in Section 1 need to have the same amount written in.
- Additionally, the same amount from letters **J & M** need to match the same amount in Section 4, page 2 of the Care & Expense Statement.

Section 2: In-Home Care - Must be completed by the care provider (Only if applicable).

Section 3: Other Care Facility – Must be completed by the Facility (Manager, Supervisor, Administrator, etc.) [Only if applicable].

Section 4:

- **First Line:** Must be signed & dated by the Facility or care provider/attendant.
- **By the dollar sign:** Enter the amount being paid to the Facility or care provider (this amount must match what is entered in letters J & M of Section 1.
- **Signature Line:** Veteran must sign & date it.
  * Alternate signer may sign in lieu of Veteran, as needed.

VA Form (21-2680)

Examination for Housebound Status or Permanent Need for Regular Aid & Attendance (21-2680)

- This form is 3 pages and must be completed & signed by a Physician.
- Special Monthly Pension (SMP) will be selected for block 13 of page 1.

COUNTY OF Placer
HEALTH & HUMAN SERVICES
VETERANS SERVICES

Income & Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity (21P-0969) – 11pages

Cover Sheet, Page 1:

Box 1, 2 and 3: Enter Veteran's information.
Box 4, 5 and 6: Enter Surviving Spouse information
Box 7: Check the Surviving Spouse box only.

Page 2-11:

- Answer all questions to the best of your ability.
- If you check yes for any question, enter the Surviving Spouse's name and information (income & asset).
- Provide verification for any income & asset being declared.

- **Section V: Interest, Royalties, and Dividends**

Page 6: This page is where interest earned/gained is entered from any asset owned by the Surviving Spouse.

- Provide current verification of asset being declared.

****Please ensure to write the Veteran's last name, first name and Social Security Number on the upper right-hand corner of every page that is not a VA form.**

Veterans Services, 1000 Sunset Blvd. Suite 115, Rocklin, CA 95765 veterans@placer.ca.gov
916-780-3290 ● www.placer.ca.gov/veterans ● fax 916-780-3299

OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

NOTE: Please read the Privacy Act and Respondent Burden below before completing the form.

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

NOTE: You can ***either*** complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to expedite processing of the form.

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*

2. CLAIMANT'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
Month Day Year

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***

6. VETERAN'S SOCIAL SECURITY NUMBER

7. VETERAN'S SEX
☐ MALE ☐ FEMALE

8. VETERAN'S SERVICE NUMBER *(If applicable)*

9. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA?
☐ YES ☐ NO

11. TELEPHONE NUMBER *(Include Area Code)*

12. EMAIL ADDRESS *(If applicable)*

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: ***(Choose all that apply)***

☐ **COMPENSATION** ☐ **PENSION**

NOTE: Only check the box below if you are a surviving dependent of the veteran.

☐ **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)**

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at **www.va.gov**. If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits***; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE

14B. DATE SIGNED *(MM,DD,YYYY)*

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*

(**NOTE**: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

CDVA

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization please complete VA Form 21-22, *Appointment of Individual as Claimant's Representative*. When completed you can mail ***or*** fax this form to the appropriate intake center address shown on Page 4. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH
Month Day Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. &
Street
Apt./Unit Number City
State/Province Country USA ZIP Code/Postal Code

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. &
Street
Apt./Unit Number
State/Province Country USA ZIP Code/Postal Code

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

California Department of Veterans Affairs

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A
CVSO
veterans@placer.ca.gov
(916) 780-3290

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15
Oakland: Oakland.oakland@calvet.ca.gov

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NUMBER

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☑ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☑ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	23B. DATE SIGNED *(MM/DD/YYYY)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

Department of Veterans Affairs

INFORMATION AND INSTRUCTIONS TO HELP YOU COMPLETE THE AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

GENERAL INFORMATION

At VA, we recognize and respect the importance of privacy. Personal information that we collect is kept confidential to the extent provided by law. In accordance with the Privacy Act and applicable confidentiality statutes, VA will only disclose the information in its custody or control in the following circumstances: where the individual identifies the particular information and consents to its use; where disclosure of the information is required by law; or where the disclosure is otherwise legally permitted, including release for a purpose compatible with the purpose for which it was collected.

By law, VA must have your written permission (an "authorization") to use or give out your claim or benefit information for any purpose that is not permitted by all applicable legal authorities. You may revoke your written permission at any time, except if VA has already acted based on your permission.

QUESTIONS	SPECIFIC INSTRUCTIONS
1-5	In this section, give us the veteran's identification information to include name, social security number, VA file number, date of birth and the veteran's service number, if applicable.
6-9	In this section, provide the beneficiary/claimant's identification information, who ***is not*** the veteran.
10-13	In Item 10 VA will give your personal benefit or claim information to the person or organization you enter in this box. You may select only ***one person*** or ***one organization***. If you designate an organization, you must also identify one or more individuals in that organization to whom VA may disclose your benefit or claim information. This form ***cannot*** be used to disclose federal tax information to third parties. IMPORTANT: The information provided in Item 6, "Name of Beneficiary/Claimant Who Is Not the Veteran," ***cannot*** be the same information provided in Item 10. Item 13 tells VA the duration of your consent. If you do not want your authorization to be effective indefinitely, tell us when to stop releasing your personal benefit or claim information to your authorized third party in Item 13. Check the box that applies and fill in dates, if applicable.
14	Select the security question you would like us to ask your designated third party and provide the answer. This question will be asked each time your designated third party contacts the VA.

WHERE DO I SEND MY COMPLETED WORK?

Send your signed authorization in by utilizing the following methods:

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs **Evidence Intake Center** **PO Box 4444** **Janesville, WI 53547-4444**	**VA gov: www.va.gov** **Direct Upload via access.va.gov**

NOTE: You should make a copy of your signed authorization for your records before mailing it to VA. You can only have one VA Form 21-0845, *Authorization to Disclose Personal Information to a Third Party*, on file with VA at a time.

WHAT IF I CHANGE MY MIND?

If you change your mind and do not want VA to give out your personal benefit or claim information, you may notify us in writing, or by telephone at 1-800-827-1000 or electronically via the Internet at https://iris.custhelp.va.gov. Upon notification from you VA will no longer give out benefit or claim information (except for the information VA has already given out based on your permission).

OMB Approved No. 2900-0736
Respondent Burden: 5 minutes
Expiration Date: 04/30/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs (VA) permission to release your personal beneficiary or claim information to a third party. This form ***may not be executed*** by any beneficiary recognized as incompetent for VA purposes, nor can VA ***accept*** this form from any beneficiary recognized as incompetent for VA purposes.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may ***either*** complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly to expedite processing the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER *(If known)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

6. NAME OF BENEFICIARY/CLAIMANT WHO IS ***NOT*** THE VETERAN *(First, Middle Initial, Last)*

7. ADDRESS OF BENEFICIARY/CLAIMANT *(Number and Street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

8. TELEPHONE NUMBER *(Include Area Code)*

9. EMAIL ADDRESS *(Optional)*

SECTION III - CONTACT INFORMATION

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION SPECIFIED BELOW TO ONE PERSON ***OR*** ONE ORGANIZATION LISTED BELOW. PROVIDE THE NAME AND ADDRESS OF THE PERSON YOU HAVE CHOSEN TO RECEIVE INFORMATION FROM VA IN ITEMS 10A AND 10B ***OR*** PROVIDE THE NAME AND ADDRESS OF THE ORGANIZATION YOU HAVE CHOSEN AND THE NAME OF THE ORGANIZATION'S REPRESENTATIVE IN ITEMS 10C AND 10D.

A. NAME OF PERSON *(First, Middle Initial, Last Name)*

B. ADDRESS OF PERSON

No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

NOTE: An organization may have more than one representative. Include the first and last name of any additional representatives.

C. NAME OF ORGANIZATION *(Include name of representative(s))*

D. ADDRESS OF ORGANIZATION

No. &
Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

11. I, THE BENEFICIARY/CLAIMANT AUTHORIZE VA TO CONTACT THE PERSON ***OR*** ORGANIZATION LISTED IN ITEM 10A OR 10C FOR THE PURPOSE OF PROVIDING THE FOLLOWING INFORMATION PERTAINING TO MY VA RECORD *(Check only one box below to tell VA the specific benefit or claim information you want disclosed)*

☐ LIMITED INFORMATION (Go to Item 12) ☐ ANY INFORMATION (Go to Item 13)

12. IF YOU SELECTED "LIMITED INFORMATION", FILL ALL THAT APPLY

☐ Status of pending claim or appeal ☐ Amount of money owed VA ☐ Other (Specify below)

☐ Current benefit and rate ☐ Request a benefit payment letter

☐ Payment history ☐ Change of address or direct deposit

13. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

☐ One time only ☐ From the date of signing below until

(Specify date - MM, DD, YYYY)

☐ Ongoing until written notice is given to VA to terminate

14. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY ***ONE*** SECURITY QUESTION BOX IN ITEM 14A AND PROVIDE THE ANSWER IN ITEM 14B.

A. SECURITY QUESTION	B. ANSWER
☐ The city and state your mother was born in	
☐ The name of the high school you attended	
☐ Your first pet's name	
☐ Your favorite teacher's name	
☐ Your father's middle name	

SECTION IV - DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

15. VETERAN SIGNATURE *(Do NOT print)*	16. DATE SIGNED *(MM,DD,YYYY)*

PRIVACY ACT INFORMATION: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

ALTERNATE SIGNER CERTIFICATION FORM (21-0972)

INSTRUCTIONS

This form is to be completed by the individual signing the benefit application form on behalf of the veteran/claimant. **Note:** For purposes of this form, the individual signing the form on behalf of the veteran/claimant is referred to as the "alternate signer."

SECTIONS	SPECIFIC INSTRUCTIONS
1	In this section, give us the veteran's identification information to include name, social security number, VA file number, date of birth, select if the veteran has ever filed a claim with VA and the veteran's service number, if applicable.
2	In this section, provide the beneficiary/claimant's identification information, who is **not** the veteran. Only complete if Veteran deceased.
3	In this section, provide the alternate signer's identification information to include, name, current address, alternate signer phone number, e-mail (if applicable) and alternate signer's relationship to the veteran/claimant.
4	In this section, select the incapacity the veteran/claimant suffers from. Check all that apply.
5	In this section, have the alternate signer sign and date Block 19A & 19B.

OMB Control No. 2900-0849
Respondent Burden: 15 minutes
Expiration Date: 01/31/2023

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

ALTERNATE SIGNER CERTIFICATION

INSTRUCTIONS: This form is to be completed by the individual signing the benefit application form on behalf of the veteran/claimant. **Note**: For purposes of this form, the individual signing the form on behalf of the veteran/claimant is referred to as the "alternate signer." Your accurate and complete answers to the questions on this form are important to help VA complete the veteran/claimant's claim.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may ***either*** complete the form online or by hand. Please print your information using blue or black ink, neatly, and legibly to help process the form.

IMPORTANT: Submit this form along with the appropriate benefit application form. The application form depends on the benefit you are claiming on behalf of the veteran/claimant. Also, submit any supporting documents or evidence to help VA complete the claim. See page 1 for a list of appropriate benefit application forms.

1. VETERAN'S NAME *(First, middle initial, last)*

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH
Month Day Year

5. HAS THE VETERAN EVER FILED A CLAIM WITH VA?
☐ YES ☐ NO

6. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(Complete this section if the claimant is other than the veteran)*

7. CLAIMANT'S NAME *(First, middle initial, last)*

8. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

9. CLAIMANT'S SOCIAL SECURITY NUMBER

10. CLAIMANT'S RELATIONSHIP TO VETERAN
☐ SPOUSE ☐ PARENT ☐ CHILD

11. CLAIMANT'S PREFERRED TELEPHONE NUMBER *(Include Area Code)*

12. CLAIMANT'S PREFERRED E-MAIL ADDRESS *(If applicable)*

SECTION III: ALTERNATE SIGNER'S IDENTIFICATION INFORMATION

13. ALTERNATE SIGNER'S NAME *(First, middle initial, last)*

14. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

15. ALTERNATE SIGNER'S PREFERRED TELEPHONE NUMBER *(Include Area Code)*

16. ALTERNATE SIGNER'S PREFERRED E-MAIL ADDRESS *(If applicable)*

17. ALTERNATE SIGNER'S RELATIONSHIP TO VETERAN/CLAIMANT (***Note***: *You must check at least one box)*

☐ A COURT-APPOINTED REPRESENTATIVE
☐ AN ATTORNEY IN FACT OR AGENT AUTHORIZED TO ACT ON BEHALF OF THE VETERAN/CLAIMANT UNDER DURABLE POWER OF ATTORNEY
☐ A PERSON WHO IS RESPONSIBLE FOR THE CARE OF THE VETERAN/CLAIMANT, TO INCLUDE BUT NOT LIMITED TO A SPOUSE OR OTHER RELATIVE
☐ A MANAGER OR PRINCIPAL OFFICER ACTING ON BEHALF OF AN INSTITUTION WHICH IS RESPONSIBLE FOR THE CARE OF THE VETERAN/CLAIMANT

VETERAN'S SSN

SECTION IV: VETERAN/CLAIMANT INFORMATION

18. VETERAN/CLAIMANT IS: *(Check **ALL** that apply)*

☐ UNDER 18 YEARS OF AGE

☐ MENTALLY INCOMPETENT TO PROVIDE SUBSTANTIALLY ACCURATE INFORMATION NEEDED TO COMPLETE THE CLAIMS FORM, OR TO CERTIFY THAT STATEMENTS MADE ON THE FORM ARE TRUE AND COMPLETE, OR

☐ PHYSICALLY UNABLE TO SIGN THE CLAIMS FORM

SECTION V: ALTERNATE SIGNER'S DECLARATION OF INTENT

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the veteran/claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing my authority to act for the veteran/claimant with a judge's signature and date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the veteran/claimant and my authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the veteran/claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

19A. AUTHORIZED SIGNER'S SIGNATURE ***(Required) (Sign in ink)***	19B. DATE SIGNED *(MM,DD,YYYY)*

20. REMARKS *(If any)*

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the veteran/claimant.

RESPONDENT BURDEN: We need this information to determine entitlement to act as the alternate signer for a veteran/claimant in submitting a claim for VA benefits (38 U.S.C. 5101). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public.do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

AID & ATTENDANCE WORKSHEET
(PLEASE COMPLETE ALL PERTINENT INFORMATION)
3 PAGE SUPPLEMENTAL SHEETS

SECTION I: INFORMATION FOR THE VETERAN			
NAME: (Last, First, Middle)		SOCIAL SECURITY NUMBER:	
DATE OF BIRTH:	PLACE OF BIRTH: (City, State)		
DATE OF DEATH:	PLACE OF DEATH: (City, State)		
DOES THE VETERAN RECEICVE MONEY FROM THE VA? YES ☐	NO ☐	IF YES, HOW MUCH?	
DOES VETERAN REQUIRE A&A YES ☐ NO ☐		DOES SPOUSE REQUIRE A&A YES ☐ NO ☐	
PLEASE PROVIDE A PHYSICIAN REPORT (21-2680) FOR CLAIMANT(s)			
SECTION II: CURRENT MARRIAGE			
NEVER MARRIED ☐	MARRIED ☐	DIVORCED ☐	WIDOWED ☐
DATE OF MARRIAGE: (Month, Day, Year)			
PLACE OF MARRIAGE: (CITY & STATE)			
# OF TIMES VETERAN MARRIED		# OF TIMES SPOUSE MARRIED	
IF THE VETERAN OR SPOUSE HAS BEEN MARRIED MORE THAN ONCE, PROVIDE INFORMATION ON PG.3			
SECTION III: INFORMATION FOR SPOUSE			
FULL NAME: (Last, First, Middle)	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	
DOES SPOUSE LIVE WITH VETERAN: YES ☐	NO ☐	IF NO, WHY SEPARATED:	
SECTION IV: WHERE DO WE SEND CORRESPONDENCE?			
NAME:	HOME:	CELL:	
ADDRESS:	CITY/STATE/ZIP:		
E-MAIL:		RELATIONSHIP:	
SECTION V: INFORMATION ON MILITARY SERVICE:			
DATE OF ENTRY:	DATE OF SEPARATION:		
ARMY ☐ NAVY ☐ AIR FORCE ☐	MARINES ☐	COAST GUARD ☐	MERCHANT ☐ OTHER ☐
REMARKS:			

SECTION VI: GROSS MONTHLY INCOME

	SOURCE	VETERAN	SPOUSE
PENSION	SOCIAL SECURITY (Before Medicare Deduction)	$	$
PENSION		$	$
PENSION		$	$
CIVIL SERVICE RETIREMENT		$	$
MILITARY RETIREMENT	DFAS	$	$
VA DISABILITY	VA	$	$
INTEREST/DIVIDENDS		$	$
IRA MINIMUM DISTRIBUTION (Annual)		$	$
RENTAL INCOME		$	$
OTHER		$	$

SECTION VII: MEDICAL EXPENSES

	SOURCE	VETERAN	SPOUSE
MEDICARE	Social Security	$	$
HEALTH INSURANCE		$	$
HEALTH INSURANCE		$	$
DENTAL INSURANCE		$	$
VISION INSURANCE		$	$
LONG TERM CARE		$	$
MEDICATIONS		$	$
FACILITY/		$	$
CAREGIVER		$	$
OTHER		$	$

SECTION VIII: ASSETS

	SOURCE	VETERAN	SPOUSE
CHECKING		$	$
SAVINGS		$	$
CHECKING		$	$
SAVINGS		$	$
STOCKS/BONDS/MUTUAL FUNDS		$	$
IRA		$	$
ANUITY		$	$
RENTAL PROPERTY		$	$
OTHER		$	$
OTHER		$	$

ONLY RETURN THIS PAGE IF MARRIED MORE THAN ONCE

ALL BOXES MUST BE ENTERED

PRIOR MARRIAGE INFORMATION FOR VETERAN

WHO MARRIED	NAME:	
	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE:		DATE ENDED:
PLACE OF MARRIAGE:		PLACE ENDED:
WHO MARRIED	NAME:	
	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE:		DATE ENDED:
PLACE OF MARRIAGE:		PLACE ENDED:
WHO MARRIED	NAME:	
	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE:		DATE ENDED:
PLACE OF MARRIAGE:		PLACE ENDED:

PRIOR MARRIAGE INFORMATION FOR SPOUSE

WHO MARRIED	NAME:	
	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE:		DATE ENDED:
PLACE OF MARRIAGE:		PLACE ENDED:
WHO MARRIED	NAME:	
	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE:		DATE ENDED:
PLACE OF MARRIAGE:		PLACE ENDED:
WHO MARRIED	NAME:	
	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE:		DATE ENDED:
PLACE OF MARRIAGE:		PLACE ENDED:

OMB Control No. 2900-0004
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 11 before completing the form.

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, first, middle)	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)

4. VETERAN'S SEX	5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER
☐ MALE ☐ FEMALE	☐ YES ☐ NO (If "Yes," provide the file number in Item 6)	

7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?	8. VETERAN'S SERVICE NUMBER	9. WHAT IS THE VETERAN'S DATE OF DEATH? (MM,DD,YYYY)
☐ YES ☐ NO		

10. WHAT IS YOUR NAME? (First, middle, last name)	11. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
	☐ SURVIVING SPOUSE ☐ PARENT ☐ CHILD ☐ CUSTODIAN FILING FOR CHILD

12. WHAT IS YOUR SOCIAL SECURITY NUMBER?	13. WHAT IS YOUR DATE OF BIRTH? (MM,DD,YYYY)	14. ARE YOU A VETERAN?
		☐ YES ☐ NO

15A. WHAT IS YOUR ADDRESS?	15B. YOUR TELEPHONE NUMBER(S) (include Area Code)
Street address, rural route, or P.O. Box Apt. number	DAYTIME
	EVENING
City State ZIP Code Country	CELL PHONE

16A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)	16B. YOUR ALTERNATE E-MAIL ADDRESS (If applicable)

17. WHAT ARE YOU CLAIMING? (Check all that apply)

☐ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ SURVIVORS PENSION ☐ ACCRUED BENEFITS

SECTION II: VETERAN'S SERVICE INFORMATION *(COMPLETE ONLY IF THE VETERAN WAS NOT RECEIVING VA COMPENSATION OR PENSION BENEFITS AT THE TIME OF DEATH)*

(Skip to Section III if the veteran was receiving VA compensation or pension benefits at the time of his or her death)

18A. DID THE VETERAN SERVE UNDER ANOTHER NAME?	18B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:
☐ YES ☐ NO (If "Yes," complete Item 18B) (If "No," skip to Item 18C)	

18C. VETERAN ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	18D. BRANCH OF SERVICE	18E. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY)

18F. PLACE OF LAST SEPARATION

19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*?	19B. DATE OF ACTIVATION (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," answer Items 19B, 19C and 19D)	

19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?	19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

20A. WAS THE VETERAN EVER A PRISONER OF WAR?	20B. DATES OF CONFINEMENT
☐ YES ☐ NO (If "Yes," complete Item 20B) (If "No," skip to Section III)	FROM: TO:

SECTION III- MARITAL INFORMATION *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)*

*(Skip to Section IV if you are **NOT** claiming benefits as the surviving spouse of the veteran)*

TELL US ABOUT THE VETERAN'S MARRIAGES

21A. HOW MANY TIMES WAS THE VETERAN MARRIED (including marriage to you)?

21B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	21C. TO WHOM MARRIED (first, middle, last name)	21D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21E. HOW MARRIAGE ENDED (death, divorce)	21F. DATE (month, day, year) and PLACE MARRIAGE ENDED (city/state or country)

21G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21D, PLEASE EXPLAIN:

TELL US ABOUT YOUR MARRIAGES

22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN? ☐ YES ☐ NO

22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran)

22C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country)	22D. TO WHOM MARRIED (first, middle, last name)	22E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	22F. HOW MARRIAGE ENDED (death, divorce, marriage has not ended)	22G. DATE (month, day, year) and PLACE MARRIAGE ENDED (city/state or country)

22H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22E, PLEASE EXPLAIN:

23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE? ☐ YES ☐ NO

24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD? ☐ YES ☐ NO

25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH? ☐ YES ☐ NO (If "No," complete Item 26)

26. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

27. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID? ☐ YES ☐ NO (If "Yes," provide explanation):

SECTION IV: CHILD OF THE VETERAN *(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)*

*(Skip to Section V if you are **NOT** claiming benefits for a child(ren) of the veteran)* (If necessary, attach a separate sheet)

28A. NAME OF CHILD (First, middle initial, last name)	28B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	28C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

If claiming benefits as the surviving spouse or custodian filing for a child, in items 29A through 29D tell us about the children listed in Item 28A who ***do not*** live with you.

29A. NAME OF CHILD (First, middle initial, last name)	29B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	29C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	29D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION V: VETERAN'S PARENT *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN)*

*(Skip to Section VI if you are **NOT** claiming benefits as the parent of a veteran)*

30A. WHAT IS YOUR MARITAL STATUS? (Check one)

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED

30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce, etc.)

30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE **SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)***

31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)	31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)	31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?

31D. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO (If "Yes," complete Item 31E)	31E. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If applicable)

32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF *MAJORITY* (AGE 18 IN MOST STATES)? ☐ YES ☐ NO (If "Yes," skip to Item 34)	32B. DATE(S) OF PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control) (MM DD YYYY) *to* (MM DD YYYY) (MM DD YYYY) *to* (MM DD YYYY)

32C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? (Explain fully)

33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 32B

A. NAME (FIRST, MIDDLE, LAST)	B. ADDRESS
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country

34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN, PROVIDE THE NAMES OF THE BIOLOGICAL PARENTS, IF DECEASED, PROVIDE THE DATE(S) OF DEATH.

A. NAME (FIRST, MIDDLE, LAST)	B. DATE OF DEATH (MM,DD,YYYY)

SECTION VI: DIC *(COMPLETE ONLY IF CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (DIC))*

*(Skip to Section VII if you are **NOT** claiming DIC)*

35. WHAT BENEFIT ARE YOU CLAIMING?

☐ DIC ☐ DIC under 38 U.S.C. 1151 (RARE)

36. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION VII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

37. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☐ NO *(If "Yes," please complete and attach with this application, VA Form 21-2680, Exam for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNRP), or Clinical Nurse Specialist (CNS).)*

38A. ARE YOU NOW IN A NURSING HOME?

☐ YES ☐ NO *(If "Yes," answer Items 38B and 38C. Also, submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.)*

38B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?

38C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

☐ YES ☐ NO *(If "No," complete Item 38D)*

38D. HAVE YOU APPLIED FOR MEDICAID?

☐ YES ☐ NO

SECTION VIII: INCOME AND ASSETS *(COMPLETE ONLY IF CLAIMING SURVIVORS PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming survivors pension benefits or parents DIC)*

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.
- If you are a surviving parent claimant, you must report income for yourself and your spouse.

39. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

☐ YES ☐ NO (If "YES," complete Item 40) (If "NO," skip to Item 41)

40. GROSS MONTHLY INCOME (Attach a separate sheet if necessary)

SOCIAL SECURITY RECIPIENT	GROSS MONTHLY AMOUNT
	$
	$
	$
	$
	$

41. DO YOU OWN YOUR PRIMARY RESIDENCE? (Parents' DIC claimants skip to Item 43A)

☐ YES ☐ NO

42A. WHAT IS THE SIZE OF THE LOT ON WHICH YOUR PRIMARY RESIDENCE SITS? (Square Feet)

Square Feet:_____

42B. COULD PART OF YOUR LOT BE SOLD *WITHOUT SELLING YOUR RESIDENCE?*

☐ YES ☐ NO (If "YES," complete and attach VA Form, 21P-0969, *Income and Asset Statement*)

IMPORTANT: VA matches income information reported with Federal tax information. Report ALL income you and your dependents receive on the appropriate sections of this form and VA Form 21P-0969, Income and Asset Statement, if appropriate.

43A. **OTHER THAN SOCIAL SECURITY**, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

☐ YES ☐ NO

43B. **OTHER THAN SOCIAL SECURITY**, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

☐ YES ☐ NO

43C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN $10,000 IN ASSETS? (NOTE: Assets are all the money and property you or your dependents own. Assets ***do not*** include your primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation)

☐ YES ☐ NO

43D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust)

☐ YES ☐ NO

43E. DID YOU ANSWER "YES," TO ANY OF THE QUESTIONS IN ITEMS 43A THRU 43D?

☐ YES ☐ NO (If "Yes," you ***must*** also complete VA Form 21P-0969, *Income and Asset Statement*)

SECTION IX: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, Medical Expense Report.

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet on pages 12 and 13.

44. ARE YOU CLAIMING UNREIMBURSED MEDICAL EXPENSES?

☐ YES ☐ NO (If "No," skip to Section X)

45A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	45B. PAID TO (Name of provider, insurance company, nursing home, etc.)	45C.PURPOSE (Medicare premiums, nursing home, etc.)	45D. DATE PAID (MM,DD,YYYY)	45E. HOURLY RATE/HOURS (In-home Provider only)	45F. AMOUNT YOU PAY

SECTION X: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 46, 47, and 48 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

46. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☐ CHECKING Account No.:_____

☐ SAVINGS Account No.:_____

☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

47. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	48. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION XI: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.*

I certify I have enclosed all information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 49, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

49. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

50A. CLAIMANT'S SIGNATURE **(REQUIRED)**	50B. DATE SIGNED

SECTION XII: WITNESSES TO SIGNATURE *(COMPLETE ONLY IF CLAIMANT SIGNED ITEM 45A WITH AN "X")*

51A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	51B. PRINTED NAME AND ADDRESS OF WITNESS
52A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	**52B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IB 10-454
May 2019

Quick Reference Guide
Income and Assets for Financial Assessment

Income: *Payments from any source unless specifically excluded. The following sources of income are counted for the purposes of completing the financial assessment (means test):*

Count:

- Alimony
- Allowances
- Benefits Subject to Garnishment
- Complaint Settlement
- Cooperative (Co-op) Dividends
- Department of Labor Employment Programs
- Dependency and Indemnity Compensation – This benefit program pays a monthly payment to a surviving spouse, child, or parents of a deceased military service member or Veteran.
- Farm Income/Conservation Resource Program Payments
- Foreign Currency Conversion
- Gambling/Lottery Winnings
- GI Bill
- Gifts and Inheritance of Property or Cash (The fair market value of gifts or inherited property is countable in the year they are received)
- Individual Retirement Account (IRA) Distributions
- Interest and Dividends
- Life Insurance Proceeds (Death Benefit paid to Veteran or spouse)
- Net Profits and Depreciation from Business, Farm and Ranch, Real Estate,
- Partnership, and S Corporations (Depreciation is added back in as income)
- Other Income (Prizes/Awards, Inheritances)
- Payments from Stocks and Bonds, Capital Gains
- Pensions, Annuities, Railroad Retirement
- Revocable Trust
- Royalties (Books, Music, Art, etc.)
- Settlements:
    - Alaska Native Claims Settlement Act (amounts ***exceeding*** $2,000 per individual per annum - including cash dividends on stock received from a Native Corporation)
    - American Indian Beneficiaries from trust or restricted lands (amounts ***exceeding*** $2,000 per individual per calendar year)
- Social Security Benefits and Death Benefit Payment (including retroactive Lump Sum Payment from previous years)
- Timber Sales
- Unemployment Compensation

- VA Disability Compensation – For the purposes of completing a financial assessment, the gross household income for a Service-connected Veteran who is receiving VA disability compensation and is married to a Nonservice-connected Veteran who is completing the financial assessment, VA disability compensation benefits would be countable income for the household
- Value of Room and Board/Housing Allowances
- Wages (Employment), Salaries, Bonuses, Severance Pay, Tips, and Other Accrued Benefits, etc.
- Workers Compensation

NOTE: The above list is not all inclusive.

The following sources of income are not counted for the purposes of completing the financial assessment (commonly known as a means test):

Do Not Count:

- Caregiver Payments
- Chore Service Payments
- Crime Victims Compensation Act Payments
- Disaster Relief Payments or Proceeds of Casualty Insurance
- Discharge of Indebtedness
- Federal Emergency Management Agency (FEMA) Disaster Insurance Payments
- Federal Government Sponsored Economic Stimulus Refunds
- Foster Care Payments
- Income from Domestic Volunteer Service Act Program
- Income Tax Refunds
- Loans (Reverse Mortgages)
- Maintenance
- Needs-Based Payments from Government Agency
- Payments for participation in a program of Rehabilitative Services
- Provisional Income
- Relocation Expenses
- Scholarships and Grants from school attendance
- Settlements:
  - Agent Orange
  - Alaska Native Claims Settlement Act (income of up to $2,000 per individual per annum - including cash dividends on stock received from a Native Corporation)
  - American Indian Beneficiaries from trust or restricted lands (income of up to $2,000 per individual per calendar year)
- VA Pension Payments
- Welfare, Supplemental Security Income (SSI), Compensated Work Therapy (CWT), Incentive Therapy (IT) earnings
- Withheld Social Security Overpayments

NOTE: The above list is not all inclusive.

Deductible Medical Expenses: *May be used to reduce other countable income for purposes of increasing pension benefits. In order to be deducted from income, out-of-pocket non-reimbursed medical expenses must exceed 5% of the VA Maximum Annual Pension Rate for the previous year.*

VA National Income Thresholds link:
https://www.va.gov/HEALTHBENEFITS/apps/explorer/AnnualIncomeLimits/HealthBenefits

The list below shows many of the common deductible medical expenses.

Note: This list is not all inclusive. Allow all expenses that are directly related to medical care.

- Abdominal supports
- Acupuncture service
- Ambulance hire
- Anesthetist
- Arch supports
- Artificial limbs and teeth
- Back supports
- Braces
- Cardiographs
- Chiropodist
- Chiropractor
- Convalescent home (for medical treatment only)
- Crutches
- Dental service, for example, cleaning, x-ray, filling teeth
- Dentures
- Dermatologist
- Drugs, prescription and nonprescription
- Gynecologist
- Hearing aids and batteries
- Home health services
- Hospital expenses
- Insulin treatment
- Invalid chair
- Lab Tests
- Lip reading lessons designed to overcome a disability
- Lodging incurred in conjunction with out-of-town travel for treatment (to be determined on a facts-found basis)
- Medicare Premiums, Parts B & D
- Medical Insurance Premiums
- Neurologist
- Nursing services for medical care, including nurse's board paid by claimant
- Occupational therapist
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Osteopath, licensed
- Pediatrician
- Physical examinations
- Physician
- Physical therapy
- Podiatrist
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Sacroiliac belt
- Seeing-Eye dog and maintenance
- Speech therapist
- Splints
- Surgeon
- Telephone/teletype special communications equipment for the deaf
- Transportation expenses for medical purposes (41.5 cents per mile effective January 1, 2009, plus parking and tolls or actual fares for taxi, buses)
- Vaccines
- Wheelchairs
- Whirlpool baths for medical purposes
- X-rays

Examples of Medical, Funeral/Burial, and Educational Deductions

1. **Processing Deduction for Medical Expenses:**

   Situation: For income year 2010, the Veteran paid $8,000 in out-of-pocket non-reimbursed medical expenses from January 1, 2010 to December 31, 2010. The medical expense deductible is $775 (5% of the maximum allowable pension rate for the previous year).

   Results: The Veteran will be able to deduct $7,225 of the $8,000 paid in medical expenses. ($775 is deducted from $8,000 to satisfy the required medical deductible, e.g., $8,000 - $775 = $7,225).

2. **Processing Deduction for Funeral/Burial Expenses:**

   Situation: The spouse died on March 1, 2010. The final funeral/burial expenses paid by the Veteran were $5,500.

   Results: The Veteran will be able to deduct the entire amount of $5,500 paid for funeral/burial expenses.

3. **Processing Deduction for Educational Expenses (deductible for Veteran only):**

   Situation: The Veteran paid $3,000 in educational expenses (including tuition, fees, books, and necessary materials).

   Results: The Veteran will be able to deduct the entire amount of $3,000 paid in educational expenses.

Note: Effective January 1, 2009, the deductible transportation expense for medical purposes is 41.5 cents per mile.

Reference: The general rule set forth in Title 38 Code of Federal Regulations (38 CFR) § 3.271 is that all income is countable unless specifically excluded by 38 CFR § 3.272. Non-reimbursed medical, funeral/burial, and educational expenses are explained in Title 38 United States Code Service, (USCS) § 1503, 38 CFR §§ 3.272(g), 3.272(h)(1), 3.272(h)(2)(i) , 3.272(i), and M21-1MR, Part V, Subpart iii, Chapter 1, Section G.

For More Information: If you have additional questions, please contact the Health Eligibility Center (HEC), Income Verification Division (IVD) at 1-800-929-VETS (8387).

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR A SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

☐ YES ☐ NO (If "NO," continue to Step 2)

(If "YES," ***all*** payments to the facility qualify as medical expenses in Items 45A thru 45F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?
- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers.

☐ YES ☐ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

☐ YES ☐ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension or special monthly DIC in Item 37?

☐ YES ☐ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

☐ YES ☐ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension or special monthly DIC. Please report the amount you pay the facility for lodging and meals separate from the amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** as medical expenses in Items 45A thru 45F. Skip to Step 8)
(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider***; and (2) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

☐ YES ☐ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disabilty)
(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

☐ YES ☐ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)
(If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 45A thru 45F. Payment to this facility for meals and lodging ***do not*** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to _____
(Name of person staying at your facility)
and his or her care at this facility _____.
(Name and address of facility)

_____ _____
(Name, Signature and Title of Person Certifying for the Facility) (Date Certified)

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

STEP 1. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

☐ YES ☐ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Item 37?

☐ YES ☐ NO (If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

☐ YES ☐ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 45A thru 45F amounts you pay an in-home attendant for: (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

☐ YES ☐ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant ***must be a health care provider***. Only report payments to the in-home attendant for ***health care services or assistance with ADLs*** provided by the health care provider as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

☐ YES ☐ NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 45A thru 45F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs ***do not*** qualify as medical expenses)

STEP 6. Check all activities below that the attendant assists the veteran or disabled person with:

ADLs: ☐ EATING ☐ BATHING/SHOWERING ☐ DRESSING ☐ TRANSFERRING ☐ USING THE TOILET

IADLs: ☐ SHOPPING ☐ FOOD PREPARATION ☐ HOUSEKEEPING ☐ LAUNDERING ☐ MANAGING FINANCES ☐ HANDLING MEDICATIONS ☐ USING THE TELEPHONE ☐ TRANSPORTANTION FOR NON-MEDICAL PURPOSES

STEP 7. **In-Home Attendant Certification**: Please submit a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs and IADLs.

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and

reflects the current environment pertaining to _____
(Name of Person Requiring Care)

and his or her care from _____.
(Name of Attendant)

_____ _____
(Name, Signature and Title of Certifying Official) (Date Certified)

Care & Expense Statement

Section 1: General Information *(To be completed by the facility administrator or care provider. Please print.)*

A. Social Security Number of the Veteran: _____

B. Veteran's Name: _____

C. Patient's Name: _____

D. Check the box which describes the patient's care status:

☐ In-Home Care
☐ Nursing Home Care
☐ Other Care Facility (*Foster Home, Adult Day Care, Rest Home, Group Home, or Assisted Living*)

E. Name of facility or care provider: _____

F. Phone number of facility or care provider: _____

G. Address of facility or care provider: _____

_____

H. Date entered facility or in-home care began: _____

I. Will the patient need this care indefinitely? ☐ Yes ☐ No

If No, when will the care end? _____

J. Total monthly charge for the patient: $_____ per month

K. Has the patient applied for Medi-Cal (Medicaid) ☐ Yes ☐ No

L. Is part of the patient's cost covered by Medicaid, Medicare, Insurance, or other source?

☐ Yes ☐ No

If Yes, please answer the following:

What is the Source of payment? _____

What is the monthly amount covered by this source? $_____ per month

When did the coverage begin? _____

M. What amount does the Veteran or patient pay from their own funds which is not reimbursed by one of the sources above? $_____ per month

Continue on page 2
Be sure to sign and date in Section 4

Section 2: In-Home Care (*To be completed by the care provider*)

A. Do you provide any medical or nursing services for the patient? ☐ Yes ☐ No

i.e., Administering medication, physical or mental therapy, assisting with ADL's (personal hygiene, dressing, bathing, etc.)

B. Please indicate the activities of daily life (ADLs) with which you assist the Veteran:

☐ Help with getting out of bed ☐ Help with dressing ☐ Help with incontinence
☐ Help with bathing ☐ Help with feeding ☐ Help with toileting
☐ Help with ambulating (walking, movement, etc.)

☐ Other assistance: _____

_____

_____

C. Are you a licensed health professional? (RN, LVN, or LPN) ☐ Yes ☐ No

If Yes, provide your license number: _____

Section 3: Other Care Facility (*To be completed by the facility administrator*)

A. Type of facility: ☐ Assisted Living ☐ Rest Home ☐ Foster Home ☐ Adult Day Care
☐ Group Home ☐ Other _____

B. Do you provide any medical or nursing services for the patient? ☐ Yes ☐ No

i.e., Administering medication, physical or mental therapy, assisting with ADL's (personal hygiene, dressing, bathing, etc.)

C. Describe the services you provide: _____

_____

D. If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional (RN, LVN, LPN) ☐ Yes ☐ No

E. We must have the monthly charge broken down into the following categories:

1) Base Rate (Includes room, meals, laundry, housekeeping): $_____ per month

2) Medical and Nursing Services: $_____ per month

Section 4: Signatures (*To be completed by the facility administrator/care provider and veteran/widow*)

I certify that the above statements are true and correct to the best of my knowledge and belief.

_____ _____
Signature of facility administrator or care provider Date

I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying $_____ per month for my care from my own funds.

_____ _____
Signature of Veteran or Beneficiary Date

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 09-30-2021

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)*
Month Day Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. GENDER
☐ MALE ☐ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. PREFERRED E-MAIL ADDRESS *(Optional)*

9. PREFERRED MAILING ADDRESS (*Number and street or rural route, P. O. Box, City, State, ZIP Code and Country*)

No. &
Street

Apt./Unit Number City

State/Province Country . ZIP Code/Postal Code

SECTION II: CLAIM INFORMATION

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S SOCIAL SECURITY NUMBER

12. RELATIONSHIP OF CLAIMANT TO VETERAN

13. BENEFIT YOU ARE APPLYING FOR (*Choose One*)

☐ **Special Monthly Compensation (SMC)** - Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.

☐ **Special Monthly Pension (SMP)** - Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

SECTION III: INFORMATION OF EXAMINATION

14. DATE OF EXAMINATION

15. HOME ADDRESS

16A. IS CLAIMANT HOSPITALIZED?
☐ YES ☐ NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED

16C. NAME AND ADDRESS OF HOSPITAL

PATIENT/VETERAN'S SOCIAL SECURITY NO.

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 25 through 39)*

18A. AGE	18B. WEIGHT	18C. HEIGHT
	ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

19. NUTRITION	20. GAIT

21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*

☐ YES ☐ NO

27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

29A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		
☐ ☐		

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*

☐ YES ☐ NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? *(If "No," provide examples and rationale to support your conclusion.)*

☐ YES ☐ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO.

33. POSTURE AND GENERAL APPEARANCE *(Attach a separate sheet of paper if additional space is needed)*

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE *(Attach a separate sheet of paper if additional space is needed)*

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

36. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

37. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

38. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

39. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐ YES
☐ NO *(If "YES," give distance) (Check applicable box or specify distance)*

☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet pate at **http://www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Attachment to VA Forms 21P-527, 21P-527EZ, 21P-534, 21P-534EZ, and 21-526)

IMPORTANT: This is ***not*** a stand-alone form. Only complete this attachment if you are directed to do so when you complete ***one*** of the following:

1. Section VI on VA Form 21P-527 or Section VII on VA Form 21P-527EZ
2. Section VII on VA Form 21P-534 or Section VIII on VA Form 21P-534EZ
3. Section VIII on VA Form 21-526

VETERAN/CLAIMANT PERSONAL INFORMATION		
1. VETERAN'S NAME (Last, First, Middle)	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S FILE NUMBER (If known)
4. CLAIMANT'S NAME (Last, First, Middle)	5. CLAIMANT'S SOCIAL SECURITY NUMBER	6. CLAIMANT'S TELEPHONE NUMBER

7. TYPE OF CLAIMANT (Check only one box)

☐ VETERAN ☐ SURVIVING SPOUSE ☐ SURVIVING CHILD ☐ PARENT

IMPORTANT INFORMATION FOR CLAIMANTS

NOTE - The term **"assets"** means the fair market value of all property that an individual owns, including all real and personal property(excluding the value of your or your dependent's primary residence including the residential lot area, not to exceed 2 acres) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

If you are a **Veteran**, you must report income and assets for:

- yourself
- your spouse (***unless*** you live apart ***and*** you are estranged ***and*** you do not contribute to your spouse's support)
- your child or children (***unless*** you do not have custody* ***and*** you do not contribute to your child's or children's support)

If you are a **Surviving Spouse,** you must report income and assets for:

- yourself
- any child of the veteran who is in your custody*

If you are a **Surviving Child** or the **Custodian of a Surviving Child**, you must report income and assets for the:

- child
- child's custodian (unless the child's custodian is an institution)
- custodian's spouse

If you are a **Parent**, you must report income** for:

- yourself
- your spouse (even if your spouse is the veteran's other parent. If your spouse is the veteran's other parent, you must ***both*** file claims)

*Child custody for pension purposes is defined in 38 C.F.R. § 3.57(d). A natural or adoptive parent has custody of a child unless custody is legally removed. For pension purposes, a child who has attained age 18 remains in the custody of the person who had custody before the child turned age 18 unless custody is legally removed.

** Parent's DIC claimants do ***not*** need to ***report*** or ***provide*** documentation of their assets.

NOTICE

IMPORTANT: VA will compare the information you report on this form to Internal Revenue Service (IRS) and Social Security Administration (SSA) records to verify your income for the past three tax years for which information is available. Information from the IRS or SSA that conflicts with the income information you provide with your application may delay your claim and/or reduce your benefit amount.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at: www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0829
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

(Attachment to VA Forms 21P- 527, 21P-527EZ, 21P-534, 21P-534EZ, and 21-526)

SECTION I: RETIREMENT INCOME AND DISTRIBUTIONS (If additional space is needed attach a separate sheet)

1. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS INCLUDING, BUT NOT LIMITED TO, DISTRIBUTIONS FROM A RETIREMENT PLAN, SUCH AS:
   - Military Retirement
   - Civil Service Retirement
   - IRA
   - SEP
   - Qualified Plans
   - Pensions
   - Annuities
   - Black Lung

☐ YES ☐ NO (If "No," skip to Section II)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHO IS THE INCOME PAYER? (Name of business, financial institution, etc.)	C. WHAT IS YOUR CURRENT AND/OR EXPECTED INCOME? (Provide documentation of current income and expected income changes)	D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME? (Provide documentation of assets)
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	

SECTION II - UNEMPLOYMENT INCOME *(If additional space is needed attach a separate sheet)*

2. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE UNEMPLOYMENT INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section III)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED UNEMPLOYMENT INCOME? (Provide documentation of current income and expected income changes)
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $

SECTION III - SAVINGS BONDS *(If additional space is needed attach a separate sheet)*

3. DO YOU OR YOUR DEPENDENTS OWN A SAVINGS BOND OR RECEIVE OR EXPECT TO RECEIVE INTEREST FROM A SAVINGS BOND WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section IV)

A. WHO OWNS THE SAVINGS BOND? (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED ANNUAL INCOME (interest earned)?** (Attach a copy of the savings bond)	**C. WHAT IS THE CURRENT FACE VALUE OF THE SAVINGS BOND?**
	WHAT IS THE GROSS ANNUAL INCOME? $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	$
	WHAT IS THE GROSS ANNUAL INCOME? $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	$
	WHAT IS THE GROSS ANNUAL INCOME? $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	$
	WHAT IS THE GROSS ANNUAL INCOME? $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	$

SECTION IV - RENTAL PROPERTY, FARM OR BUSINESS INCOME *(If additional space is needed attach a separate sheet)*

4. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INCOME FROM RENTAL PROPERTY, FARM OR BUSINESS WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section V)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHAT IS YOUR OR YOUR DEPENEDENTS CURRENT OR EXPECTED INCOME FROM THIS SOURCE?** (Provide documentation of current income and expected income changes)	**C. WHAT KIND OF INCOME IS THIS?** (Check applicable box)	**D. WHAT IS THE VALUE OF YOUR PORTION OF THE PROPERTY, FARM, OR BUSINESS?** (**Note:** Subtract the amount of Mortgages or other encumbrances specific to the property. Provide available documentation)
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	

SECTION V - INTEREST, ROYALTIES, AND DIVIDENDS *(If additional space is needed attach a separate sheet)*

5. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INTEREST, DIVIDENDS, OR ROYALTIES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section VI)

IMPORTANT: Do ***not*** report income you have already reported in Section III (Savings Bonds) or Section IV (Rental Property, Farm or Business Income).

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHO IS THE INCOME PAYER?** (Name of business, financial institution, etc.)	**C. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED INCOME?** (Provide documentation of current income and expected income changes)	**D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME?** (Provide documentation of assets)
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	

SECTION VI - WAGES - INCLUDING SELF-EMPLOYMENT ***(If additional space is needed attach a separate sheet)***

6. ARE YOU OR YOUR DEPENDENTS RECEIVING WAGES OR EXPECTING TO RECEIVE WAGES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section VII)

A. WAGE RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHAT ARE YOUR OR YOUR DEPENDENTS CURRENT WAGES AND/OR EXPECTED WAGES?** (Provide documentation of current wages and expected wage changes)
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE WILL CHANGE AND EXPECTED WAGE AMOUNT $

SECTION VII - DISCONTINUED INCOME IN THE PRIOR TAX YEAR *(If additional space is needed attach a separate sheet)*

7. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME ***LAST YEAR*** THAT IS NO LONGER BEING RECEIVED OR WAS A ONE-TIME PAYMENT?

☐ YES ☐ NO (If "No," skip to Section VIII)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHO WAS THE INCOME PAYER?** (Name of business, financial institution, etc.)	**C. WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?**	**D. WHEN DID THE INCOME STOP?** (MM,DD,YYYY)
		$	
		$	
		$	
		$	

NOTE: Parent's DIC Claimants Only - You ***do not*** have to complete Sections VIII thru XI. Return to the application form. Your certification, signature and date on the application form applies to this attachment.

Pension Claimants - Continue to complete the attachment.

SECTION VIII - ASSETS PREVIOUSLY NOT REPORTED *(If additional space is needed attach a separate sheet)*

8. DO YOU OR YOUR DEPENDENTS HAVE ASSETS ***NOT*** ALREADY REPORTED, SUCH AS NON-INTEREST-BEARING ACCOUNTS, CASH, STOCKS, BONDS, OR REAL ESTATE?

☐ YES ☐ NO (If "No," skip to Section IX)

A. ASSET OWNER (Veteran, Spouse, Child, Parent, Custodial, etc.)	B. WHAT IS THE CURRENT CASH VALUE OF THE ASSET? (Provide a bank or other official statement showing the current value. Do not report assets you have already reported in Sections I through VII)	C. AMOUNT OWED ON THE ASSET OR AMOUNT MORTGAGED OR OTHERWISE ENCUMBERED? (Provide documentation of mortgages or other encumbrances)
	$	$
	$	$
	$	$
	$	$

SECTION IX - ASSET TRANSFERS *(If additional space is needed attach a separate sheet)*

9. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ASSETS?

☐ YES ☐ NO (If "No," skip to Section X)

A. WHO OWNED THE ASSET? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER (Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____

SECTION IX: ASSET TRANSFERS *(Continued)*

A. WHO OWNED THE ASSET? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER (Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset that was reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset that was reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____

SECTION X: ANNUITIES AND TRUSTS (Attach a separate sheet if more than one annuity or trust is involved)

10A. IN THE CURRENT YEAR OR THE PRIOR THREE TAX YEARS, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS TO A TRUST OR PURCHASE AN ANNUITY?

☐ Yes ☐ No (If "No," skip to Section XI)

10B. WHAT WAS THE MARKET VALUE OF THE ASSET AT THE TIME OF TRANSFER OR ANNUITY PURCHASE? $

10C. WHAT WAS THE DATE THE ASSET WAS TRANSFERRED? (MM,DD,YYYY)

10D. DID YOU PURCHASE AN ANNUITY WITH THE ASSETS?	10E. PROVIDE DATE OF PURCHASE	10F. PROVIDE NAME OF PERSON THE ASSET WAS PURCHASED FROM (First-Middle-Last)
☐ Yes ☐ No (If "Yes," complete Items 10E through 10G)		

10G. PROVIDE TYPE OF ANNUITY PURCHASED *(Give details and attach documentation)*

10H. WERE THE ASSETS USED TO ESTABLISH A TRUST?	10I. PROVIDE TAX NUMBER	10J. PROVIDE DETAILS AND ATTACH DOCUMENTATION
☐ Yes ☐ No (If "Yes," complete Items 10I through 10J)		

10K. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?

☐ Yes ☐ No

SECTION XI - WAIVER OF RECEIPT OF INCOME *(If additional space is needed attach a separate sheet)*

11. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TO WAIVE ANY RECEIPT OF INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "NO," skip this section. This attachment is complete. Return to the application. Your certification, signature and date on the application form applies to this attachment)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED WAIVED INCOME?** (Provide documentation of income and expected income changes)
	CURRENT MONTHLY GROSS WAIVED INCOME $ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $

THIS *ATTACHMENT FORM* IS COMPLETE. RETURN TO THE *APPLICATION FORM*. YOUR CERTIFICATION, SIGNATURE AND DATE ON THE APPLICATION FORM APPLIES TO THIS ATTACHMENT.